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Clinical Case Studies 5-6

FROM THE RECORDS OF THE
PITTSBURGH DIAGNOSTIC CLINIC
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FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly, but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Single Age 41 years.

CHIEF COMPLAINT

Attacks of right side weakness and numbness.

PRESENT ILLNESS

This patient has had three attacks of marked weakness and numbness of the entire right side of the body including the right side of the face. The first attack came on suddenly eighteen months ago while he was in his store, when he suddenly became rather dizzy, but was able to walk to the rear of the store, whereupon, within a few moments he became semi-conscious and remained in that condition for three or four days during which the entire right side of the body was paralyzed. In about two weeks the paralysis began to subside and from that time on for about three months he was only partially incapacitated, being able to sit up in bed, and walk if assisted. He states that the entire right side of the body, including the face, arm, and leg were very numb and quite weak, so that although he could hold an object for a moment or two, it would soon slip out of his fingers. There was apparently no difficulty in controlling the bladder and he was able to swallow; he was also able to read and there was no double vision, but he states that his tongue was a little thick so that it was hard for him to speak distinctly. Bowels were normal; there was no headache and no nausea or vomiting. In about six months he was almost entirely recovered so he was able to walk about unassisted and spend an hour or two in his store, but there was a slight amount of residual sensations of numbness of the hand and leg and also an aching sensation in the forearm and lower leg, worse when the weather was cold or damp. While he was in this stage, about six months after the first attack, he developed a second one which was not as severe as the first; apparently there was no preliminary period of semi-consciousness, but merely a sudden increase in the weakness and numbness of

the right side which persisted for several days and then began to subside. About eight months after this second attack he developed a third attack which likewise was not as severe in its onset or duration as the first attack. For the past month he has been able to go about again, but there is a residual sensation of numbness, involving particularly the bottoms of the feet and the palms of the hands and to a lesser extent, the lower leg and the right forearm and also the right side of the face. There is also some weakness of the hand, but he is able to sign his name and feed himself and carry out all ordinary movements. No headaches, but occasionally he gets sharp, painful sensations in the top of the skull, apparently referred under the scalp. No visual disturbances of any kind, no ringing in the ears, no difficulty in swallowing.

Since the development of the first attack he has reduced his weight by limitation of diet, from 240 pounds to 195 pounds. Aside from the symptoms referable to the right side he otherwise feels perfectly normal, there being no shortness of breath, palpitation of the heart, gastro-intestinal or genito-urinary disturbances. He sleeps well.

PAST HISTORY

Past history is entirely negative up until the onset of the present illness. No acute or chronic illness; no trouble with the eyes, ears, nose, throat, heart, lungs, gastro-intestinal or genito-urinary tracts.

Habits—long hours of work in his drug store, usually from seven in the morning until eleven at night. The patient chews tobacco but does not smoke. Alcohol—usually took one or two drinks of strong liquor after the end of working hours each evening, but rarely to excess.

Venereal history—entirely negative.

Social history—patient is single.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 66 inches Weight 194 pounds Temperature 98.6°

Patient is the short, chunky, short-necked type of individual, still weighs 195 pounds, is overweight and must have been markedly obese when he weighed 240 pounds before the present illness. There is no cyanosis or jaundice. His speech is a little thick at times and there is an intermittent, somewhat spasmodic quality to his enunciation, but this does not suggest a true "scanning" type of speech disturbance. There is no sign of mental disturbance of any kind, or of emotional instability.

HEAD AND NECK

Ears—negative. Eyes—pupils are round, a little larger than usual, but are equal and react normally to light and accommodation. Associated movements of the eyeballs are normal; there is no nystagmus. Mouth—teeth are rather poorly preserved, gums show slight pyorrhea. Throat—moderately injected, tonsils are deep, rather ragged and a few crypts are seen, but there is no sign of chronic infection. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—a little enlarged to the left, Point of Maximal Impulse being in fifth Interspace, just in nipple line; no abnormal widening of the cardiac dullness at the base. Rate is 78, regular in force and rhythm; sounds are somewhat "tapping" in quality, but otherwise normal, and no murmurs are heard. Pulse—78, regular, no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness; spleen is not felt; liver to costal margin, edge is not felt.

EXTREMITIES

No edema, although the patient states that at night he develops edema of the right leg.

NEUROLOGICAL TESTS

Sensory: There is some disturbance of tactile sense in the distal portion of the right arm and right leg beginning in the arm at about one-third down from the elbow and extending out to the fingers and beginning in the leg just below the knee; there is also slight dulling of tactile sense over the right side of the trunk but no evident dulling about the right shoulder or upper right arm region.

Sensations to heat and cold: The sensations are disturbed in the distal portion of the arms and legs and also along the right trunk, but in the upper right arm and in the shoulder region they are normal. There is a little suggestion of the peripheral type of zoning in the disturbance of temperature appreciation.

Muscle sense: This is apparently undisturbed as far as movements of the hands and legs are concerned, but there is difficulty in appreciating whether the toe is being turned up or down.

Romberg test: Negative.

Vibration sense: This is normal, very accurate and quick all over the affected areas.

Reflexes: There is exaggeration of all the reflexes of both arms and legs, and there is not much difference on the two sides, although one gets the impression that the reflexes are a little more active in the right arm and leg. Plantar response on the left is normal, but on the right it is equivocal, most of the time the toe turning up but occasionally remaining stationary and rarely turning down. Abdominal reflexes are entirely absent on the right side and very difficult and uncertain on the left, although one gets the impression of a sluggish abdominal response over the lower left abdominal region. Cremasteric reflexes are quick and active on both sides.

BLOOD PRESSURE Systolic 240 Diastolic 140.

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration reports requested on Special Studies.

GENERAL HISTORY

White Male Single Age 39 years

CHIEF COMPLAINT

Aching in the lower legs on exertion.

PRESENT ILLNESS

This patient has suffered with the present symptoms more or less constantly for the past twelve years. The symptoms are rather clear-cut and consist essentially in the development of an aching sensation in both legs below the knees after a moderate amount of exertion. Most of the discomfort is in the calves of the legs but there is also a tendency for it to appear in the feet. Any exercise of the legs will bring on this aching sensation and if the exercise is continued without rest the aching will eventually become so severe as to compel the patient to stop for rest. The time of development of the aching varies with the severity of the exercise: thus, in walking he finds that he can continue for as much as five or even ten minutes before the symptoms appear; however, if he runs, these symptoms appear within a minute or two. Very marked exertion of the legs, such as lifting a weight, will bring it on immediately. There is no true cramp and no tingling or numbness, but simply a very marked aching. On resting the legs the symptoms disappear very rapidly. He has learned to anticipate and in part avoid these symptoms while engaged in his work as a salesman. Thus, if he finds that he must go from one point to another that is farther than one or two blocks he will ride on the street car, and in walking from office to office he always makes it a point to sit down five or ten minutes at each stop. The weather and the temperature have no effect of which he is conscious. He does not know of any change in the appearance of the lower legs such as paleness and blueness. He has never developed any true cramps, but only an aching.

These symptoms have been present for at least ten or twelve years without much variation in severity. However, the patient

dates the real beginning of the present condition to about eighteen years ago when he developed diphtheria for which he was given antitoxin. Immediately following the diphtheria he noticed excessive weakness of the legs which persisted for several months. He then was apparently quite well until two or three years later when he again developed very severe diphtheria. Because it was not properly diagnosed it was not treated by antitoxin. Immediately following this he was again bothered by excessive weakness of the legs and he believes that the symptoms at that time were essentially the same as those of which he now complains. There was again improvement and in about a year he was apparently back to normal, and remained well until about 12 years ago, when he took up work which necessitated walking about ten miles a day. Very soon after he began this work the symptoms developed of which he now complains and they have been present ever since. At first his condition was ascribed to weak arches and arch supports were fitted with practically no benefit.

In addition to the above localized symptoms, the patient states that after a day of normal physical activity he develops a feeling of general tiredness and exhaustion, together with a sensation of aching over the eyes and a feeling as though he were mentally exhausted, especially noticeable in the form of poor memory. All these symptoms are relieved by a hot bath.

In the past month he has noticed vague pains in the lower back suggesting sacro-iliac or lumbago, apparently having no relation to the symptoms described in the legs.

It may be of significance that this patient has always been subject to what he describes as "weak circulation" in the hands. This he describes as a tendency to blueness and coldness in the hands so that they finally become stiff and interfere with the finer motions of the fingers. This was quite marked when he was a boy to such an extent that he recalls when in school he would frequently be compelled to put his hands in warm water to relieve the stiffness. In the last five or ten years this condition in the hands is not so marked as it was when he was a boy and he practically never is compelled to immerse his hands in warm water. Otherwise, the patient feels perfectly well. There are no headaches or tiredness or nervousness. He eats and sleeps normally and feels energetic at all times.

PAST HISTORY

General health has always been perfect with the exception of this so-called poor circulation of the hands which was especially

noticeable when he was a young boy. No history of any acute illness except the diphtheria noted above. Frequent attacks of tonsillitis, rather severe, two or three times a year until the tonsils were removed five years ago, since when he has had none. No trouble with the eyes or ears, no palpitation of the heart, edema or nycturia. Vascular disturbance of the hands noted under present illness. Appetite and digestion were normal, bowels always regular.

Venereal history—negative.

Family history—father is living and perfectly well. Mother is living, general health is good, but she notices poor circulation in the hands as shown by a tendency to moisture and coldness on dry days. One brother living and well, no sisters.

Social history—patient is a white male adult, single. His habits are regular, no alcohol or tobacco to excess.

No marked change in the weight in the last five or ten years.

PHYSICAL EXAMINATION

GENERAL

Height 68½ inches Weight 159 pounds Temperature 97°

Patient is well developed and well nourished. Skin is clear; there is no cyanosis, jaundice, or abnormal pigmentation.

HEAD AND NECK

Eyes—pupils are equal and react normally; associated movements are normal. Ears—negative. Mouth—many devitalized teeth. Throat—tonsils thoroughly removed. Glands—none palpable. Thyroid—isthmus palpable; lobes are not felt.

THORAX

Lungs are clear throughout.

Heart—normal in size and contour. Rate is 72, regular in force and rhythm. Sounds are normal, no murmurs. Pulse—72, regular in force and rhythm. Palpation of radial artery does not show any apparent abnormal thickening.

ABDOMEN

No masses or areas of tenderness; spleen is not felt; liver to costal margin, edge is not felt.

EXTREMITIES

There is no edema; reflexes are exaggerated but of normal quality. No tremor, no evidence of hypertrophy or atrophy of muscles.

Lower extremities—feet are cold and moist. There is no cyanosis of the feet. The anterior and posterior tibial arteries are palpable and the pulsation is easily felt, but these arteries impress one as showing an abnormal degree of leathery thickening. The hands are cool and moderately moist. No cyanosis or abnormal paleness. Radial artery does not seem abnormally thick. The arches of the feet seem normal and there is no tenderness about the tendons.

BLOOD PRESSURE

Systolic 105 Diastolic 80.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.